

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05001

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Salt</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>50 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Salt</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u> d. STREET ADDRESS <u>1316 August St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Daniel</u> Last <u>Boone</u> 4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1958</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 5, 1876</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Rabbi</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>Madison Boone</u> 14. MOTHER'S MAIDEN NAME <u>Rebecca Madison</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>213-224351</u> 17. INFORMANT <u>Sara Mae Thornton</u> Address <u>716 August St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>THURSTON HARRISON</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10 April 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 12, 1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u> 22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John Back</u> ADDRESS <u>Easton MD</u> 24a. REC'D BY REGISTRAR <u>Deedee</u> DATE <u>APR 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Deedee</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is partially obscured by a large vertical stamp.

RECEIVED
APR 14 1958
BUREAU V. S.

5007 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 8 hrs. 25 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.				d. STREET ADDRESS Bellevue Avenue			
3. NAME OF DECEASED (Type or print) First GRACE Middle BROWN Last BROWN				4. DATE OF DEATH Month 4 Day 23 Year 1958			
5. SEX Fe.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 30, 1892	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 5 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Luther Gardner		14. MOTHER'S MAIDEN NAME Emma Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs Grace B Bartlett Address (daughter)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Septal myocardial infarction (ventricular aneurysm) INTERVAL BETWEEN ONSET AND DEATH sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension 2 yrs. (c) atherosclerotic coronary thrombosis 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 8:45 p.m. , 19 48 , to 2:30 a.m. , 19 58 , that I last saw the deceased alive on 23 Apr , 19 58 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thurston Harrison M.D.				ADDRESS (Street, city or town, state) Centreville, Md. DATE SIGNED 23 Apr 58			
PHYSICIAN'S NAME (Type) THURSTON HARRISON				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 4/25/58				22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery			
22d. LOCATION (City, town, or county) (State) Centreville Maryland				24a. REC'D BY REGISTRAR APR 28 '58			
24b. REGISTRAR'S SIGNATURE W. H. Burch				25. FUNERAL DIRECTOR'S SIGNATURE James H. Burch ADDRESS Centreville, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie</u> <u>Burke</u> <u>Jr.</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>8</u> <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/20</u>	9. AGE (In years last birthday) yrs. <u>38</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessie Burke, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>unknown</u>		17. INFORMANT Address <u>Helen Burke (wife) Centreville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolyte imbalance</u> 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pyloric stenosis</u> DUE TO (c) <u>Duodenal ulcer</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton 16, Maryland</u>			
DATE SIGNED <u>9 April 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Worton Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schell, Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Schell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

2008

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12-1-28		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
ATTORNEY		HEART DISEASE		NATURAL		NONE		NONE		NONE		NONE		NONE	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CHURCH	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU K.T.
APR 14 1968

RECEIVED

5009

CERTIFICATE OF DEATH

Reg. Dist. No. 05004

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Drummond</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1958</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Abraham Drummond</u>	
14. MOTHER'S MAIDEN NAME <u>Irene Seth</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Abraham R. Drummond (father)</u> Address <u>205 Earle Ave. Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u> DUE TO (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>58</u> to <u>4/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>58</u> , and that death occurred at <u>8</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Baybutt</u>		M.D. <u>205 Earle Ave. Easton, Md.</u> DATE SIGNED <u>4/24/58</u>	
PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hosp. Paston Md</u> ADDRESS <u>2080296XVO</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Ow. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH</p>	
<p>19. SIGNATURE OF CEMETERY</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF ASSISTANT</p>		<p>22. SIGNATURE OF CLERK</p>	
<p>23. SIGNATURE OF RECEPTIONIST</p>		<p>24. SIGNATURE OF TELEPHONE OPERATOR</p>	
<p>25. SIGNATURE OF MAIL ROOM</p>		<p>26. SIGNATURE OF RECORDS SECTION</p>	
<p>27. SIGNATURE OF IDENTIFICATION SECTION</p>		<p>28. SIGNATURE OF LABORATORY</p>	
<p>29. SIGNATURE OF RADIOLOGY</p>		<p>30. SIGNATURE OF PATHOLOGY</p>	
<p>31. SIGNATURE OF ANATOMY</p>		<p>32. SIGNATURE OF HISTOLOGY</p>	
<p>33. SIGNATURE OF MICROBIOLOGY</p>		<p>34. SIGNATURE OF PHARMACY</p>	
<p>35. SIGNATURE OF NURSING</p>		<p>36. SIGNATURE OF DENTISTRY</p>	
<p>37. SIGNATURE OF OPTOMETRY</p>		<p>38. SIGNATURE OF PODIATRY</p>	
<p>39. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>40. SIGNATURE OF NURSE</p>	
<p>41. SIGNATURE OF LABORATORY ASSISTANT</p>		<p>42. SIGNATURE OF RADIOLOGY ASSISTANT</p>	
<p>43. SIGNATURE OF PATHOLOGY ASSISTANT</p>		<p>44. SIGNATURE OF ANATOMY ASSISTANT</p>	
<p>45. SIGNATURE OF HISTOLOGY ASSISTANT</p>		<p>46. SIGNATURE OF MICROBIOLOGY ASSISTANT</p>	
<p>47. SIGNATURE OF PHARMACY ASSISTANT</p>		<p>48. SIGNATURE OF DENTISTRY ASSISTANT</p>	
<p>49. SIGNATURE OF OPTOMETRY ASSISTANT</p>		<p>50. SIGNATURE OF PODIATRY ASSISTANT</p>	
<p>51. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>52. SIGNATURE OF NURSE</p>	
<p>53. SIGNATURE OF LABORATORY ASSISTANT</p>		<p>54. SIGNATURE OF RADIOLOGY ASSISTANT</p>	
<p>55. SIGNATURE OF PATHOLOGY ASSISTANT</p>		<p>56. SIGNATURE OF ANATOMY ASSISTANT</p>	
<p>57. SIGNATURE OF HISTOLOGY ASSISTANT</p>		<p>58. SIGNATURE OF MICROBIOLOGY ASSISTANT</p>	
<p>59. SIGNATURE OF PHARMACY ASSISTANT</p>		<p>60. SIGNATURE OF DENTISTRY ASSISTANT</p>	
<p>61. SIGNATURE OF OPTOMETRY ASSISTANT</p>		<p>62. SIGNATURE OF PODIATRY ASSISTANT</p>	
<p>63. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>64. SIGNATURE OF NURSE</p>	
<p>65. SIGNATURE OF LABORATORY ASSISTANT</p>		<p>66. SIGNATURE OF RADIOLOGY ASSISTANT</p>	
<p>67. SIGNATURE OF PATHOLOGY ASSISTANT</p>		<p>68. SIGNATURE OF ANATOMY ASSISTANT</p>	
<p>69. SIGNATURE OF HISTOLOGY ASSISTANT</p>		<p>70. SIGNATURE OF MICROBIOLOGY ASSISTANT</p>	
<p>71. SIGNATURE OF PHARMACY ASSISTANT</p>		<p>72. SIGNATURE OF DENTISTRY ASSISTANT</p>	
<p>73. SIGNATURE OF OPTOMETRY ASSISTANT</p>		<p>74. SIGNATURE OF PODIATRY ASSISTANT</p>	
<p>75. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>76. SIGNATURE OF NURSE</p>	
<p>77. SIGNATURE OF LABORATORY ASSISTANT</p>		<p>78. SIGNATURE OF RADIOLOGY ASSISTANT</p>	
<p>79. SIGNATURE OF PATHOLOGY ASSISTANT</p>		<p>80. SIGNATURE OF ANATOMY ASSISTANT</p>	
<p>81. SIGNATURE OF HISTOLOGY ASSISTANT</p>		<p>82. SIGNATURE OF MICROBIOLOGY ASSISTANT</p>	
<p>83. SIGNATURE OF PHARMACY ASSISTANT</p>		<p>84. SIGNATURE OF DENTISTRY ASSISTANT</p>	
<p>85. SIGNATURE OF OPTOMETRY ASSISTANT</p>		<p>86. SIGNATURE OF PODIATRY ASSISTANT</p>	
<p>87. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>88. SIGNATURE OF NURSE</p>	
<p>89. SIGNATURE OF LABORATORY ASSISTANT</p>		<p>90. SIGNATURE OF RADIOLOGY ASSISTANT</p>	
<p>91. SIGNATURE OF PATHOLOGY ASSISTANT</p>		<p>92. SIGNATURE OF ANATOMY ASSISTANT</p>	
<p>93. SIGNATURE OF HISTOLOGY ASSISTANT</p>		<p>94. SIGNATURE OF MICROBIOLOGY ASSISTANT</p>	
<p>95. SIGNATURE OF PHARMACY ASSISTANT</p>		<p>96. SIGNATURE OF DENTISTRY ASSISTANT</p>	
<p>97. SIGNATURE OF OPTOMETRY ASSISTANT</p>		<p>98. SIGNATURE OF PODIATRY ASSISTANT</p>	
<p>99. SIGNATURE OF PHYSICIAN ASSISTANT</p>		<p>100. SIGNATURE OF NURSE</p>	

BUREAU V. S.

APR 28 1958

RECEIVED

5010 CERTIFICATE OF DEATH

05005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Elva</u> Middle <u>Fountain</u> Last <u>None</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 15, 1906</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Smith</u>	
14. MOTHER'S MARRIED NAME <u>Mary Roberts</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-09-1268</u>		17. INFORMANT <u>Leon Fountain</u> Address <u>(husb)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>421.1</u> DUE TO (b) <u>Cardiac dilatation & hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Aortic valvulitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anesthesia & intubation</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>219 S. West 119th St. 1 May 58</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Md. Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/3/58</u>	22b. DATE THEREOF <u>5/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clairborne Md</u>	22d. LOCATION (City, town, or county) (State) <u>Clairborne Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>		ADDRESS <u>St. Michael, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1910	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
Baltimore, Md.		None		Married		White	
9. NAME OF NEAREST RELATIVE		10. ADDRESS OF NEAREST RELATIVE		11. ADDRESS OF DECEASED		12. DATE OF DEATH	
John H. Harris		1234 Main St.		1234 Main St.		1955	
13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. SIGNATURE OF PHYSICIAN	
Home		Heart Disease		Natural		J. H. Harris	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEAREST RELATIVE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE NEAREST RELATIVE TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE MANNER OF DEATH. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE OF DEATH IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE NEAREST RELATIVE TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE MANNER OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05006

5024

FOR STATE
HEALTH DEPT.

M

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I

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Lake			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waukegan		51X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 330 Glendeneing Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last FREELAND				4. DATE OF DEATH Month April Day 4 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1939		9. AGE (in years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Months 19 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Dr. John E. Freeland				14. MOTHER'S MAIDEN NAME Rubie A. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT Dr. J. E. Freeland		Address 330 Glendeneing PL. Ill.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning 823X DUE TO Auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Auto accident DUE TO (c) Fractured rt femur							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) thrown into stream from automobile					
20c. TIME OF INJURY Month. Day. Year Hour 4-4 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) nr Easton Talbot	(County) Ind	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-5-58			
EXAMINER'S NAME (Type) Dr. Louis S. Welty		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY Northshore Garden of Memories		22d. LOCATION (City, town, or county) (State) Chicago, Illinois		
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son			ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR APR 8 '58		
24b. REGISTRAR'S SIGNATURE [Signature]							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT.



MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1958

BUREAU V. 3

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5025 CERTIFICATE OF DEATH

Reg. Dist. No. 05007

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Harrison Green		4. DATE OF DEATH Month Day Year 4 21 19 58	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/47
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbur Green		14. MOTHER'S MAIDEN NAME Emma Johns.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wilbur Green		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sickle cell Anemia - 292.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-30-58 , to 4-21-58 , that I last saw the deceased alive on 4-20-58 , and that death occurred at 10:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Winters		ADDRESS (Street, city or town, state) 210 E DOVER EASTON, MD	
PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS		DATE SIGNED 4-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/23/58	22c. NAME OF CEMETERY OR CREMATORY Williamsburg Cem.	22d. LOCATION (City, town, or county) (State) Easton, RT4 Md
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.		24a. REC'D BY REGISTRAR MAY 5 '58	
		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05008

Reg. Dist. No.

5011

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT MEDFORD HALL			4. DATE OF DEATH Month April Day 9 Year 19 58		
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1885		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY seafood packing		11. BIRTHPLACE (State or foreign country) Fairmont, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Hall			14. MOTHER'S MAIDEN NAME Celeste Waters		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert Hall Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 9/12.3 IMMEDIATE CAUSE (a) Intrathoracic hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) crushing injury to chest from falling shell conveyor DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) helping to move shell conveyor when it fell on him			
20c. TIME OF INJURY Month, Day, Year Hour 2:30 AM <input type="checkbox"/> PM <input checked="" type="checkbox"/> 4-9-58 19		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.B. Harris & Co.	
		20f. (City or town) Oxford		20g. (County) Talbot	
				20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Louis S. Welty</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Louis S. Welty				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58		22c. NAME OF CEMETERY OR CREMATORY Oxford Cem.	
				22d. LOCATION (City, town, or county) Oxford	
				(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell			ADDRESS Easton, Md.		
24a. REC'D BY REGISTRAR APR 16 '58			24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT



BUREAU V. S.

APR 16 1958

RECEIVED

5712 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Michaels,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>D.</u> Last <u>Herring</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1, 1886</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country)* <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>E.W. Herring</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Todd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Not known</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>253-07-3958</u>		17. INFORMANT <u>M. Waller Y. Herring (son)</u> Address <u>219 S. Washington St. Box 58</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Talbot</u> , 19 <u>1958</u> , to <u>April 4, 1958</u> , that I last saw the deceased alive on <u>April 4, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Box 58</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>April 5, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		22d. LOCATION (City, town, or county) (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Moore Telford</u> ADDRESS <u>St. Michaels</u>				24a. REC'D BY REGISTRAR <u>APR 9 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Stoic

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8361 6 2d.

5013 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton R.F.D.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ada Middle Mae Last Ialer		4. DATE OF DEATH Month 4 Day 12 Year 1958	
5. SEX F	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/3/11
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) North carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Prince Miller		14. MOTHER'S MAIDEN NAME Ada Briant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. xxxxxx	
17. INFORMANT Willie Evans, Philadelphia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 590x DUE TO Myocarditis Acute Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1958 to April 12, 1958 , that I last saw the deceased alive on April 12, 1958 , and that death occurred at Easton, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hayward G. Nelt M.D. 633 N. 1st St. Easton, Md. 4/14/58			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/15/58	22c. NAME OF CEMETERY OR CREMATORY Richards Cem	22d. LOCATION (City, town, or county) (State) Easton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell,		ADDRESS Easton, Md	
24a. REC'D BY REGISTRAR APR 16 1958		24b. REGISTRAR'S SIGNATURE W. J. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director. After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. EDUCATION 9. RELIGION 10. RACE 11. COLOR 12. HEIGHT 13. WEIGHT 14. BUILD 15. HAIR 16. EYES 17. SKIN 18. TENDRILS 19. TEETH 20. NAILS 21. PALM 22. SOLES 23. FEET 24. HANDS 25. WRISTS 26. ELBOWS 27. SHOULDERS 28. NECK 29. THROAT 30. CHEST 31. BACK 32. LIMBS 33. JOINTS 34. MOVEMENTS 35. SENSES 36. MENTAL STATE 37. HISTORY 38. PRESENT ILLNESS 39. CAUSE OF DEATH 40. MANNER OF DEATH 41. PLACE OF DEATH 42. TIME OF DEATH 43. SIGNATURE OF PHYSICIAN 44. SIGNATURE OF WITNESSES 45. SIGNATURE OF REGISTRAR 46. DATE OF REGISTRATION 47. PLACE OF REGISTRATION 48. OFFICIAL SEAL 49. OFFICIAL SIGNATURE 50. OFFICIAL TITLE</p>		<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. EDUCATION 9. RELIGION 10. RACE 11. COLOR 12. HEIGHT 13. WEIGHT 14. BUILD 15. HAIR 16. EYES 17. SKIN 18. TENDRILS 19. TEETH 20. NAILS 21. PALM 22. SOLES 23. FEET 24. HANDS 25. WRISTS 26. ELBOWS 27. SHOULDERS 28. NECK 29. THROAT 30. CHEST 31. BACK 32. LIMBS 33. JOINTS 34. MOVEMENTS 35. SENSES 36. MENTAL STATE 37. HISTORY 38. PRESENT ILLNESS 39. CAUSE OF DEATH 40. MANNER OF DEATH 41. PLACE OF DEATH 42. TIME OF DEATH 43. SIGNATURE OF PHYSICIAN 44. SIGNATURE OF WITNESSES 45. SIGNATURE OF REGISTRAR 46. DATE OF REGISTRATION 47. PLACE OF REGISTRATION 48. OFFICIAL SEAL 49. OFFICIAL SIGNATURE 50. OFFICIAL TITLE</p>
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BUREAU V. E.

APR 16 1938

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5714 CERTIFICATE OF DEATH

Reg. Dist. No.

06151

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown 17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Johnson</u>		4. DATE OF DEATH Month Day Year <u>April 10 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1958</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ronald Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ellen M. Johnson</u>	
17. INFORMANT Address <u>Mr. Johnson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>58</u> , to <u>4/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>58</u> , and that death occurred at <u>8:15</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin H. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Queenstown Md</u> DATE SIGNED <u>5/7/58</u>	
PHYSICIAN'S NAME (Type) <u>Irvin H. Hoyt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF <u>4-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Easton Md</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 9 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5026 CERTIFICATE OF DEATH

Reg. Dist. No. 05011

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAVITT</u>	c. LENGTH OF STAY IN 1b <u>50 YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAVITT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>L.</u> Last <u>JOHNSON JR</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24 1891</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TALBOT CO. MD</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>WILLIAM L JOHNSON SR.</u>	
14. MOTHER'S MAIDEN NAME <u>MOLLIE H. CALLAHAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218-34-9404</u>		17. INFORMANT <u>Mrs Ruth Johnson Neavitt Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO <u>Coronary Artery Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>5 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>17 June</u> , 19 <u>58</u> , to <u>23 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>23 April</u> , 19 <u>58</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Whalley</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u>	
DATE SIGNED <u>4-24-58</u>		PHYSICIAN'S NAME (Type) <u>NEAVITT</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEAVITT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NEAVITT MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hankerton Harrison</u>		24. REC'D BY REGISTRAR <u>APR 28 '58</u>	
ADDRESS <u>St. Michaels, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 60 YEARS		SEX MALE		RACE WHITE	
DATE OF DEATH APRIL 10, 1938		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESSES J. H. HARRIS		SIGNATURE OF DECEASED JAMES H. HARRIS	

RECEIVED
APR 22 1938
BUREAU V. S.

5015 CERTIFICATE OF DEATH

06152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Laurel St.		d. STREET ADDRESS 1 6 Laurel St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Karen Middle Marie Last Knopp		4. DATE OF DEATH Month April Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1958
9. AGE (In years last birthday) yrs. 1 Months 28		IF UNDER 1 YEAR 1 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Franklin Knopp, Jr.		14. MOTHER'S MAIDEN NAME Audrey Sewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) non		16. SOCIAL SECURITY NO. none	
17. INFORMANT Benjamin F. Knopp, Jr.		Address 6 Laurel St. Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DIFFUSE INTERSTITIAL PNEUMONITIS DUE TO (GROSS PATHOLOGY REPORT) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) VIRUS INFECTION DUE TO (c) 7 hours		INTERVAL BETWEEN ONSET AND DEATH LESS THAN 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/3 , 19 58 , to 4/30 , 19 58 , that I last saw the deceased alive on 4/28 , 19 58 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 12 N. HANSON ST EASTON, MARYLAND	
ACTUAL SIGNATURE L. J. Eglender M.D.		DATE SIGNED MAY 8 1958	
PHYSICIAN'S NAME (Type) Ludwig J. Eglender			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 2, 1958	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Galloway		24a. REC'D BY REGISTRAR MAY 8 1958	
ADDRESS Easton, Maryland		24b. REGISTRAR'S SIGNATURE W. Hampton Galloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2180284 XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5016 CERTIFICATE OF DEATH

Reg. Dist. No. 05012

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Michaels			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.				d. STREET ADDRESS 1121			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Lample				4. DATE OF DEATH Month 4 Day 29 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-58	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marshall R. Lample		14. MOTHER'S MAIDEN NAME Charlotte Jordan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr Marshall R Lample father		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 April , 19 58 , to 50 April , 19 58 , that I last saw the deceased alive on 29 April , 19 58 , and that death occurred at 10:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1121 St Michaels, Md DATE SIGNED 5-1-58							
ACTUAL SIGNATURE R. Frank Wootch M.D.				PHYSICIAN'S NAME (Type) R. Frank Wootch			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/30/58		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Easton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE 2080 294XVO				24a. REC'D BY REGISTRAR DATE MAY 6 1958		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-16 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. RACE White		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. DATE OF DEATH April 4, 1968		7. TIME OF DEATH 2:01 PM		8. PLACE OF DEATH Memphis, Tennessee		9. CAUSE OF DEATH Shot - Gun		10. MANNER OF DEATH Suicide	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESS (None)		13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF CORONER (None)		15. SIGNATURE OF JURY (None)	
16. SIGNATURE OF REGISTRAR (None)		17. SIGNATURE OF CLERK (None)		18. SIGNATURE OF CHIEF OF POLICE (None)		19. SIGNATURE OF DISTRICT ATTORNEY (None)		20. SIGNATURE OF JUDGE (None)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5027 CERTIFICATE OF DEATH

Reg. Dist. No.

05013

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Witman		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS XWitman,	
3. NAME OF DECEASED (Type or print) First Alice Middle Hardin Last Magee		4. DATE OF DEATH 4/22/58. Month 4 Day 22 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 19, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME John W. Hardin.		14. MOTHER'S MAIDEN NAME Lida Earle Stichberry.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Gen. John R. Hardin,		Address Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vera cavaal thrombosis DUE TO 172x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent metastatic carcinoma DUE TO of fundus of uterus (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt		ADDRESS (Street, city or town, state) 219 S. Washington St. Baltimore Md.	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		DATE SIGNED 22 Apr 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) buried		22b. DATE THEREOF April 24 58	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Park		22d. LOCATION (City, town or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Paul		ADDRESS Quincy Md	
24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5017 CERTIFICATE OF DEATH

Reg. Dist. No. 05014

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>16 da.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u>				05X2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R7D #1 - Box 254</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>W.</u> Last <u>McGUIRE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired farmer</u>		11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George McFaire</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Adolph</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Mrs. Frank Mc Guire - Federalburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> 181.0 DUE TO <u>Bladder cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/5</u> , 19 <u>58</u> , to <u>4/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED <u>4/22/58</u>			
ACTUAL SIGNATURE <u>B Cox</u> M.D. <u>Eustace J. D.</u>							
PHYSICIAN'S NAME (Type) <u>P E Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blossom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Wilburn</u> ADDRESS <u>Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN W. SMITH</i>		2. SEX <i>M</i>		3. AGE <i>45</i>		4. RACE <i>W</i>		5. PLACE OF BIRTH <i>MISSISSIPPI</i>		6. PLACE OF DEATH <i>MISSISSIPPI</i>	
7. DATE OF DEATH <i>APR 24 1958</i>		8. TIME OF DEATH <i>10:00 AM</i>		9. CAUSE OF DEATH <i>HEART DISEASE</i>		10. MANNER OF DEATH <i>NATURAL</i>		11. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
13. NAME OF HUSBAND <i>[Blank]</i>		14. NAME OF WIFE <i>[Blank]</i>		15. NAME OF CHILD <i>[Blank]</i>		16. NAME OF SISTER <i>[Blank]</i>		17. NAME OF BROTHER <i>[Blank]</i>		18. NAME OF OTHER RELATIVE <i>[Blank]</i>	
19. NAME OF NEAREST RELATIVE <i>[Blank]</i>		20. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		21. CITY OF NEAREST RELATIVE <i>[Blank]</i>		22. STATE OF NEAREST RELATIVE <i>[Blank]</i>		23. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		24. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
25. NAME OF NEAREST RELATIVE <i>[Blank]</i>		26. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		27. CITY OF NEAREST RELATIVE <i>[Blank]</i>		28. STATE OF NEAREST RELATIVE <i>[Blank]</i>		29. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		30. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
31. NAME OF NEAREST RELATIVE <i>[Blank]</i>		32. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		33. CITY OF NEAREST RELATIVE <i>[Blank]</i>		34. STATE OF NEAREST RELATIVE <i>[Blank]</i>		35. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		36. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
37. NAME OF NEAREST RELATIVE <i>[Blank]</i>		38. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		39. CITY OF NEAREST RELATIVE <i>[Blank]</i>		40. STATE OF NEAREST RELATIVE <i>[Blank]</i>		41. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		42. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
43. NAME OF NEAREST RELATIVE <i>[Blank]</i>		44. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		45. CITY OF NEAREST RELATIVE <i>[Blank]</i>		46. STATE OF NEAREST RELATIVE <i>[Blank]</i>		47. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		48. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
49. NAME OF NEAREST RELATIVE <i>[Blank]</i>		50. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		51. CITY OF NEAREST RELATIVE <i>[Blank]</i>		52. STATE OF NEAREST RELATIVE <i>[Blank]</i>		53. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		54. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
55. NAME OF NEAREST RELATIVE <i>[Blank]</i>		56. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		57. CITY OF NEAREST RELATIVE <i>[Blank]</i>		58. STATE OF NEAREST RELATIVE <i>[Blank]</i>		59. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		60. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
61. NAME OF NEAREST RELATIVE <i>[Blank]</i>		62. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		63. CITY OF NEAREST RELATIVE <i>[Blank]</i>		64. STATE OF NEAREST RELATIVE <i>[Blank]</i>		65. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		66. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
67. NAME OF NEAREST RELATIVE <i>[Blank]</i>		68. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		69. CITY OF NEAREST RELATIVE <i>[Blank]</i>		70. STATE OF NEAREST RELATIVE <i>[Blank]</i>		71. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		72. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
73. NAME OF NEAREST RELATIVE <i>[Blank]</i>		74. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		75. CITY OF NEAREST RELATIVE <i>[Blank]</i>		76. STATE OF NEAREST RELATIVE <i>[Blank]</i>		77. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		78. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
79. NAME OF NEAREST RELATIVE <i>[Blank]</i>		80. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		81. CITY OF NEAREST RELATIVE <i>[Blank]</i>		82. STATE OF NEAREST RELATIVE <i>[Blank]</i>		83. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		84. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
85. NAME OF NEAREST RELATIVE <i>[Blank]</i>		86. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		87. CITY OF NEAREST RELATIVE <i>[Blank]</i>		88. STATE OF NEAREST RELATIVE <i>[Blank]</i>		89. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		90. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
91. NAME OF NEAREST RELATIVE <i>[Blank]</i>		92. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		93. CITY OF NEAREST RELATIVE <i>[Blank]</i>		94. STATE OF NEAREST RELATIVE <i>[Blank]</i>		95. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		96. NAME OF NEAREST RELATIVE <i>[Blank]</i>	
97. NAME OF NEAREST RELATIVE <i>[Blank]</i>		98. ADDRESS OF NEAREST RELATIVE <i>[Blank]</i>		99. CITY OF NEAREST RELATIVE <i>[Blank]</i>		100. STATE OF NEAREST RELATIVE <i>[Blank]</i>		101. COUNTRY OF NEAREST RELATIVE <i>[Blank]</i>		102. NAME OF NEAREST RELATIVE <i>[Blank]</i>	

BUREAU V. E.

APR 24 1958

RECEIVED

5718 CERTIFICATE OF DEATH

Reg. Dist. No.

05015

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Federal</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u> 09x-2			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby GIRL MELVIN</u>				4. DATE OF DEATH <u>4/5/58</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/58</u>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Melvin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lee Messick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Mrs Mary Lee Messick</u> Address <u>Harlock</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus, congenital</u> 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>719 S. Washington St. Baltimore</u> DATE SIGNED <u>9/8/58</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Williams</u> ADDRESS <u>Federalburg, Md.</u>				24. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Schmidt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2080201XV6

CERTIFICATE OF DEATH

SEE OUR FILE

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]		9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]		13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF WITNESS [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. OCCUPATION [Faint text]		17. EDUCATION [Faint text]		18. RELIGION [Faint text]		19. MARITAL STATUS [Faint text]		20. SOCIAL SECURITY NUMBER [Faint text]		21. PREVIOUS ILLNESS [Faint text]		22. PREVIOUS SURGERY [Faint text]		23. PREVIOUS TRAUMA [Faint text]		24. PREVIOUS DRUGS [Faint text]		25. PREVIOUS ALCOHOL [Faint text]		26. PREVIOUS TOBACCO [Faint text]		27. PREVIOUS OTHER [Faint text]		28. PREVIOUS OTHER [Faint text]		29. PREVIOUS OTHER [Faint text]		30. PREVIOUS OTHER [Faint text]	

BUREAU V. B.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05016

5228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JAMES Last MURRAY		4. DATE OF DEATH Month Apr. Day 18, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millar		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William J. Murray		14. MOTHER'S MAIDEN NAME Madeline Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-6573	
17. INFORMANT Mrs. William J. Murray		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 wks Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-11- 19 55 , to 4-15- 19 58 , that I last saw the deceased alive on 4-15- 19 58 , and that death occurred at 11:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald F. Bartley		DATE SIGNED 4-21-58	
PHYSICIAN'S NAME (Type) Dr. Donald F. Bartley		Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Wye Church Cemetery		22d. LOCATION (City, town, or county) (State) Wye Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE APR 24 '58		24b. REGISTRAR'S SIGNATURE W. E. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1893		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APR 24 1958		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. H. HARRIS	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P.M.		98.6		60	
PLACE OF INTERMENT		CITY		COUNTY		STATE		CEMETERY		LOT	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		GREENWOOD		LOT 10	
DATE OF INTERMENT		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
APR 24 1958		10		00		P.M.		98.6		60	
NAME OF FUNERAL HOME		CITY		COUNTY		STATE		CEMETERY		LOT	
HARRIS FUNERAL HOME		BALTIMORE		BALTIMORE		BALTIMORE		GREENWOOD		LOT 10	
DATE OF FUNERAL		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
APR 24 1958		10		00		P.M.		98.6		60	

BUREAU V. S.

APR 24 1958

RECEIVED

5719 CERTIFICATE OF DEATH

Reg. Dist. No.

05017

1. PLACE OF DEATH o. COUNTY <i>Salbot.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg Md.</i> 05X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>RFD</i>			
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>L.</i> Last <i>Hobbs.</i>				4. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1958.</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 2 1904</i>	
9. AGE (In years last birthday) <i>54</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Mr Wm Brown</i>		14. MOTHER'S MAIDEN NAME <i>Lydia Hobbs.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>M P Martin Hobbs (husb)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>586x</i> DUE TO <i>Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Obstructive jaundice</i> DUE TO (c) <i>4 weeks</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cholelithiasis & duodenitis</i>		4-18-58		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Jan 56</i> , 19, to <i>4-26-58</i> 19, that I last saw the deceased alive on <i>4-25-58</i> 19, and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton Md.</i> DATE SIGNED <i>5-1-58</i>	
ACTUAL SIGNATURE <i>Arthur B. Cecil</i>		M.D. <i>Easton Md.</i>		PHYSICIAN'S NAME (Type) <i>ARTHUR B. CECIL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 24 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Concord</i>		22d. LOCATION (City, town, or county) (State) <i>Concord Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil</i>		ADDRESS <i>Heavens Denton</i>		24a. REC'D BY REGISTRAR <i>Al. Beach</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 5 '58

5020 CERTIFICATE OF DEATH

Reg. Dist. No. 05018

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1227 S. Aurora St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Poe</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11 - 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Levi Poe</u>				14. MOTHER'S MAIDEN NAME <u>Frances Camper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Not qualified</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Annie Overham (Sister)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Advanced nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advised nephrosclerosis</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> P. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Birth to death</u> , 19 <u>11</u> , to <u>1958</u> , that I last saw the deceased alive on <u>April 9, 1958</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				M.D. <u>219 S. Washington St. 10 Apr 58</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		JAN 14 1958	
FULL NAME OF DECEASED		AGE	
JOHN J. JONES		65	
SEX		M	
RACE		W	
EDUCATION		H	
OCCUPATION		C	
MARRIAGE		M	
DATE OF MARRIAGE		JAN 14 1958	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MD		JAN 14 1958	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
CORONARY ARTERY DISEASE		SUICIDE	
MYOCARDIAL INFARCTION		ACCIDENT	
HYPERTENSION		HOMICIDE	
ANGINA PECTORIS		OTHER	
CORONARY Atherosclerosis			
MURMUR OF THE HEART			
VALVULAR DISEASE			
RHEUMATISM			
OTHER			
SIGNATURE OF PHYSICIAN		DATE	
J. J. JONES		JAN 14 1958	
SIGNATURE OF WITNESS		DATE	
J. J. JONES		JAN 14 1958	
SIGNATURE OF DECEASED		DATE	
SIGNATURE OF NEXT OF KIN		DATE	
J. J. JONES		JAN 14 1958	
SIGNATURE OF BURIAL OFFICIAL		DATE	
J. J. JONES		JAN 14 1958	

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JAN 14 1958

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05019									
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak, Md.			c. LENGTH OF STAY IN 1b 2 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal oak				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS Box 104				
3. NAME OF DECEASED (Type or print) Henry Scott					4. DATE OF DEATH April 28 1958				
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/3/00		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm Hand		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nelson Scott					14. MOTHER'S MAIDEN NAME Mary Scott				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lettie Johnson, Baltimore, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 881.0 Carbon monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kerosene lamp DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholism									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gassed by improperly adjusted kerosene lamp in his room						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Royall Oak Talbot Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Louis Welch			M.D. WELTY		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-1-58		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/58		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or county) (State) Easton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.				24a. REC'D BY REGISTRAR ONTAY 5 '58		24b. REGISTRAR'S SIGNATURE Allegre			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5030 CERTIFICATE OF DEATH

05020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDANIEL		c. LENGTH OF STAY IN 1b 8 Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICIA Middle L. Last STEWART		4. DATE OF DEATH Month APR. Day 17 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> CHILD DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28, 1957
9. AGE (In years last birthday) yrs. 7 Months 9 Days 30		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) EASTON HOSPITAL, EASTON MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAWRENCE H. STEWART JR		14. MOTHER'S MAIDEN NAME BARBARA TULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lawrence H. Stewart, McDaniel Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus - severe 752X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-31 , 19 57 , to 4-17 , 19 58 , that I last saw the deceased alive on 4-17 , 19 58 , and that death occurred at 8:41 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Emory M. Reeser Jr		M.D. Admiral Md	
PHYSICIAN'S NAME (Type) Emory M. Reeser Jr		4-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/18/58	
22c. NAME OF CEMETERY OR CREMATORY SPRINGHILL CEMETERY		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE A. Hamilton Harrison, St. Michaels		ADDRESS	
24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

2080242XV6

CERTIFICATE OF DEATH

NAME OF DECEASED McDaniel		AGE 2 Mo		SEX Male		RACE White	
DATE OF BIRTH April 1938		PLACE OF BIRTH Massachusetts		CITY OF BIRTH Boston		COUNTRY OF BIRTH United States	
DATE OF DEATH April 1938		PLACE OF DEATH Massachusetts		CITY OF DEATH Boston		COUNTRY OF DEATH United States	
CAUSE OF DEATH Infantile		DISEASE OR INJURY Infantile		SPECIFIC CAUSE OF DEATH Infantile		MANNER OF DEATH Natural	
DATE OF INTERVIEW April 1938		PLACE OF INTERVIEW Massachusetts		CITY OF INTERVIEW Boston		COUNTRY OF INTERVIEW United States	
NAME OF PHYSICIAN Dr. [illegible]		NAME OF NURSE [illegible]		NAME OF MIDWIFE [illegible]		NAME OF OTHER ATTENDING PHYSICIAN [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF NURSE [illegible]		SIGNATURE OF MIDWIFE [illegible]		SIGNATURE OF OTHER ATTENDING PHYSICIAN [illegible]	
DATE OF SIGNATURE April 1938		PLACE OF SIGNATURE Massachusetts		CITY OF SIGNATURE Boston		COUNTRY OF SIGNATURE United States	
NAME OF REGISTRAR [illegible]		NAME OF CLERK [illegible]		NAME OF ASSISTANT CLERK [illegible]		NAME OF OTHER OFFICIAL [illegible]	
SIGNATURE OF REGISTRAR [illegible]		SIGNATURE OF CLERK [illegible]		SIGNATURE OF ASSISTANT CLERK [illegible]		SIGNATURE OF OTHER OFFICIAL [illegible]	
DATE OF SIGNATURE April 1938		PLACE OF SIGNATURE Massachusetts		CITY OF SIGNATURE Boston		COUNTRY OF SIGNATURE United States	

BUREAU V. S.

APR 25 1938

RECEIVED

5021 CERTIFICATE OF DEATH

05021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17x-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp				d. STREET ADDRESS Cheslerfield Avenue			
3. NAME OF DECEASED (Type or print) First Edwin Middle S. Last Valliant				4. DATE OF DEATH Month 4 Day 8 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 6, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 19 Min.		IF UNDER 24 HRS. Months 8 Days 8 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg of fertilizer				10b. KIND OF BUSINESS OR INDUSTRY Fertilizer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Edwin S. Valliant				14. MOTHER'S MAIDEN NAME Mary T. Faithful			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-28-0960		17. INFORMANT Mrs. Delmarie Valliant (wife) Address Centreville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post op - Prostatectomy DUE TO (c) 3/25/58 INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/23 , 19 58 , to 4/8 , 19 58 , that I last saw the deceased alive on 4/8 , 19 58 , and that death occurred at 12:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 4/11/58							
ACTUAL SIGNATURE P E Cox				M.D. Easton Md			
PHYSICIAN'S NAME (Type) P E Cox MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery		22d. LOCATION (City, town, or county) (State) Church Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Butler ADDRESS Prof Butler Par. Centreville, Md.				24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. 3.

APR 15 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05022

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or reburial, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 40 mins</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe (Bruceville)</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Ernest</u> Last <u>Watts</u>		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/87</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist - Fisherman Cannery - Fishing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sinclair Watts</u>		14. MOTHER'S MAIDEN NAME <u>Florence Frazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-01-7465</u>	
17. INFORMANT Address <u> </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe cerebral contusions</u> DUE TO (b) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>		20c. TIME OF INJURY Month, Day, Year <u>4-27-58</u> Hour <u>4:30</u> p.m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte 50</u>	
20f. (City or town) <u>nr. Easton</u> (County) <u>Talbot</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Lewis M. Wietz</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WIEZT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-30-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Windy Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Trappe, Maryland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heatrice E. Hewnam-John</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>2 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
HEALTH OFFICE

1932

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
AGE
SEX
RACE
OCCUPATION
EDUCATION
MARRIAGE

1. CAUSE OF DEATH
2. MANNER OF DEATH
3. DISEASES PREEXISTING AT THE TIME OF DEATH
4. MEDICAL HISTORY
5. SOCIAL HISTORY
6. FAMILY HISTORY
7. PERSONAL HISTORY
8. PHYSICAL EXAMINATION
9. LABORATORY EXAMINATIONS
10. POSTMORTEM FINDINGS
11. OTHER FINDINGS
12. SIGNATURE OF MEDICAL EXAMINER
13. SIGNATURE OF WITNESSES
14. SIGNATURE OF CORONER
15. SIGNATURE OF JURY
16. SIGNATURE OF DISTRICT ATTORNEY
17. SIGNATURE OF CLERK
18. SIGNATURE OF SHERIFF
19. SIGNATURE OF JAILER
20. SIGNATURE OF PRISON WARDEN
21. SIGNATURE OF CHIEF OF POLICE
22. SIGNATURE OF DEPUTY CHIEF OF POLICE
23. SIGNATURE OF INSPECTOR OF PRISON
24. SIGNATURE OF INSPECTOR OF JAIL
25. SIGNATURE OF INSPECTOR OF PRISON WARDEN
26. SIGNATURE OF INSPECTOR OF JAIL WARDEN
27. SIGNATURE OF INSPECTOR OF PRISON CHIEF
28. SIGNATURE OF INSPECTOR OF JAIL CHIEF
29. SIGNATURE OF INSPECTOR OF PRISON DEPUTY
30. SIGNATURE OF INSPECTOR OF JAIL DEPUTY

5023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 Port</u>				d. STREET ADDRESS <u>120 Port</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elnora Williams</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/72</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Julia Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>(Mrs) Nannie Webb</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>56</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md.</u> <u>4-10-58</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>227 Pine St-Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Rt. 2 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR - 16 1958

RECEIVED